[Date]

[Insurance Company Name]
[Prior Authorization/Appeals Department Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity / Step Therapy Exception Request
Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Member ID Number]
Group Number: [Group Number]
Claim/Reference Number: [If applicable]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to request an exception to the step therapy requirements for the medication [Requested Medication Name]. [Patient Name] has been under my care for the treatment of [ICD-10 Code/Diagnosis Name, e.g., G43.709 Chronic Migraine].

The patient currently experiences [Number] headache days per month. Based on the patient's medical history and clinical presentation, the formulary-preferred medications required by the step therapy protocol are medically inappropriate for this patient.

Clinical Justification for Exception:

- **[Trialed Medication 1]:** [Dates of use]. Resulted in [failure/intolerable side effects/lack of efficacy].
- **[Trialed Medication 2]:** [Dates of use]. Resulted in [failure/intolerable side effects/lack of efficacy].
- **Contraindications:** The patient is unable to trial [Formulary Drug Name] due to [Specific Medical Contraindication, e.g., comorbid condition, drug interaction].

In my professional medical opinion, requiring the patient to trial additional formulary agents would likely result in a significant deterioration of their condition, increased emergency department visits, and a decrease in functional status. [Requested Medication Name] is medically necessary to stabilize the patient's condition.

I request that you approve this exception and authorize coverage for [Requested Medication Name] immediately. Please contact my office at [Phone Number] if you require additional clinical documentation.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Clinic/Practice Name]

[NPI Number]
[Phone Number]